TEXAS BOARD OF HEALTH
APPLICATION FOR ADVISORY COMMITTEE APPOINTMENT

Name of Council Cardiovascular Disease and Stroke

Initial appointment **G** Reappointment **G**

Position Applied for Council Member

Please complete this application in a brief, yet informative manner. If questions are not applicable, enter "NA." Your eligibility will be determined from the information you submit on this application. No resumes will be considered.

1. Name: _____
First *Middle* *Last*

2. Race/Ethnicity:
_____ White
_____ Black
_____ Hispanic
_____ American Indian/Alaskan
_____ Asian/Pacific Islander
_____ Other: _____

3. Gender: _____ Male
_____ Female

4. Education: _____

5. Professional License, Registration or Certification, if applicable: _____

6. Relevant Experience (paid employment or volunteer): _____

7. Why do you wish to serve in this capacity? _____

8. Personal and professional achievements (include activities which address contributions you could make to the committee or board):

_____

_____

_____

_____

9. Have you ever been disciplined by any licensing board/professional or civic organization? ____Yes ____No

If yes, please explain _____

_____

10. Have you ever been convicted of a felony or a misdemeanor (excluding traffic violations)? ____Yes ____No

If yes, please explain _____

_____

11. Home Address

_____
Street or P.O. Box *Apartment #*

_____
City *State* *Zip*

_____
Area Code/Home Telephone *Facsimile Number*

12. Employment Address

_____
Name of Employer

_____
Street or P.O. Box *Suite #*

_____
City *State* *Zip*

_____
Area Code/Business Telephone *Facsimile Number*

13. Please indicate where you would like to receive future communications:

_____ Home _____ Employment

_____
Current Position Title

14. PLEASE ATTACH TWO LETTERS OF RECOMMENDATION FROM PROFESSIONAL AND/OR CIVIC ORGANIZATIONS.

15. WILL SERVICE ON THIS COUNCIL PROVIDE A PERSONAL FINANCIAL HARDSHIP?____YES ____NO

If yes, please explain _____

_____

I ATTEST THAT ALL INFORMATION CONTAINED IN THIS DOCUMENT IS TRUE AND CORRECT.

_____ _____
Signature of Nominee Date

PLEASE RETURN THIS FORM TO:

Jennifer Smith, M.S.H.P.
Chronic Disease Community and Worksite Wellness Program
Texas Department of Health, T-402
1100 West 49th Street
Austin, Texas 78756-3199